TRAINING SUPPORT PACKAGE: MEDICAL RECORDS MANAGEMENT

The Army developed a training program to teach methods for accounting for, transferring, receiving, filing, and storing medical records. The program covers the entire process, from the first assembly of the medical record to its retirement. Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG024
TSP Title	Medical Records Management
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for: MEDICAL RECORDS MANAGEMENT

This TSP Contains

TABLE OF CONTENTS

HPABG024 version 1 / Medical Records Management
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0208	Maintain Medical Records for Personnel Enrolled in the Personnel Reliability Program
081-866-0209	Forward Medical Documents/Records to the Proper Custodian
081-866-0210	Dispose of Unidentifiable Records and Forms
081-866-0211	Dispose of a Health Record (HREC)
081-866-0212	Retire an Outpatient Treatment Record (OTR)

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	5.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	5.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
HSC PAM 40-7-5	Ambulatory Patient Care Outpatient Medical Records Improvement Actions	03 Apr 1985	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
AR 50-5	Nuclear and Chemical Weapons and Material-Nuclear Surety (Reprinted w/Basic Incl C1, 07 Aug 89) (03 Oct 86)	01 Jan 1900	
DA Form 8005	Outpatient Medical Record (OMR) Orange	01 Jan 1900	
DA Form 3444-Series	Terminal Digit File for Treatment Record	01 Jan 1900	
AR 25-400-2	The Modern Army Recordkeeping System (MARKS) (26 Feb 93)	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:

35mm slide projector, hand control, and screen
Slides S HPABG024 01-

Student Materials:

Student handout "Medical Records Management Student Handout M HPABG024 01"

Classroom, Training Area, and Range Requirements	CLASSROOM 48 PER,TABLES
Ammunition Requirements	**Name** — **Student Qty** — **Misc Qty** None
Instructional Guidance	**NOTE:** Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material. The Instructor should distribute student hand-outs prior to the start of classroom presentation.
Proponent Lesson Plan Approvals	**Name** — **Rank** — **Position** — **Date**

SECTION II. INTRODUCTION

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 5 hrs
Media: PRINT

Motivator

Maintaining records with efficiency and positve control results in a pleasant work environment and contented patients.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage medical records and documents.
Conditions:	Given AR 40-66, Medical Record Administration, AR 50-5, Nuclear & Chemical Weapons and Materials-Nuclear Surety, Medical Documents, DA Form 3444-series or DA Form 8005-series folders, and APV records, HSC Pam 40-7-5, Ambulatory Patient Care and Outpatient Medical Records Improvement Actions, AR 25-400-2, The Modern Army Recordkeeping System (MARKS).
Standards:	The soldier must manage medical records and documents IAW AR 40-66 and AR 50-5.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Knowing the skills of assembling and organizing medical records is very important. Properly organized records are essential to health maintenance of the soldiers whose well-being is our responsibility. But, proper assembly and maintenance of the records is only a part of the job. Things such as accounting for records, transferring and receiving records, and filing and storage of records are just as important. From when medical records are first assembled to when that are retired, there must be dedicated procedures for ensuring their longevity. In this lesson, that is what we will discuss: "Medical Records Management."

Slide S HPABG024 01.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Screen an incoming medical record.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must screen an incoming medical record IAW AR 40-66.

1. Learning Step / Activity 1. Receiving the record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 02: Receiving the Record

a. Record receipt of the incoming medical record.
b. Initiate a new jacket if the medical record jacket is mutilated.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Checking the medical record for correct entries.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 03: Checking for Correct Entries

a. Check DA Form 3444 or DA Form 8005 series for correct information and completeness.
(1) Patient identification
a) Name.
b) Family member prefix (FMP).
c) Sponsor's social security number.
d) Unit (only on health records).
e) Blood type (only on health records).

Slide S HPABG024 04: Checking for Correct Entries

(2) Check note to physician.
a) Medical condition.
b) Personnel Reliability Program (PRP) screening.
c) Radiation screening program.
d) Flight status.
e) Medical registries.

Slide S HPABG024 05: Checking for Correct Entries

(3) Check type of record.
a) Inpatient (clinical).

b) Outpatient treatment.
c) Health.

NOTE: "Health" should be the only box checked under type of record on a Health Record.

Slide S HPABG024 06: Checking for Correct Entries

d) Health-Dental.
e) Dental (nonmilitary).
(4) Check for a signed Privacy Act Statement (DA Form 2005).

Slide S HPABG024 07: Checking for Correct Entries

b. Check the record contents for proper sequence of forms and completeness of patient identification information.

NOTE: Copies of the same form shall be grouped together and filed in reverse chronological order.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Review SF 88, Report of Medical Information.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 08: Report of Medical Examination, SF 88F

a. Check the patient information in blocks 1 through 17.
b. Check items 18 through 43 for completeness.

NOTE: Item 43 pertains to females only.

Slide S HPABG024 09: Report of Medical Examination, SF 88B

c. Check items 17 through 47for required entries.
d. Check for signatures.
e. Return to the physician for completion, if necessary.
f. File the completed form in the patient's record.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Review SF 93, Report of Medical History.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45

Media: PRINT

Slide S HPABG024 10: Report of Medical History, SF 93F

a. Ensure the patient's identification and administrative data have been recorded.
b. Ensure the patient has completed the medical history and health data sections.
c. Ensure the patient has signed the form.

Slide S HPABG024 11: Report of Medical History, SF 93F

d. Ensure the physician has completed item 25, if applicable.
e. Ensure the physician's name and date have been entered.
f. Return the form to the physician for completion, if necessary.
g. File the completed form in the patient's record.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Forward the medical record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 12: Forward the Medical Record

a. Review of health records (HRECs) may be conducted by a medical officer, a physician's assistant, or other qualified individuals.
b. Forward the health record to the appropriate Army Medical Department (AMEDD) personnel for review.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Maintain medical records for personnel enrolled in the Personnel Reliability Program (PRP).
CONDITIONS:	Given AR 40-66, and AR 50-5.
STANDARDS:	The soldier must Maintain medical records for personnel enrolled in the Personnel Reliability Program (PRP) IAW AR 40-66, AR 50-5, and AR 50-6.

1. Learning Step / Activity 1. Overviewing the Personnel Reliability Program (PRP).

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 13: Personnel Reliability Program (PRP)

a. Purpose of the PRP.
(1) Provides guidelines for the Army to identify nuclear duty positions.
(2) Provides a means of assessing the reliability of individuals whom are being considered for assignment to nuclear duty positions.

Slide S HPABG024 14: Personnel Reliability Program (PRP)

b. Personnel eligible for assignment to the PRP.
(1) Acive duty personnel.
(2) DOD civilian employees.
(3) Civilian contract personnel.

Slide S HPABG024 15: Personnel Reliability Program (PRP)

c. Disqualifying conditions.
(a) Alcohol abuse.
(b) Drug abuse.
(c) Any physical condition which may impair judgement.
(d) Lack of motivation.
(e) Negligence of duty.
(f) Punitive processes (Article 15 or Court Martial).

Slide S HPABG024 16: Personnel Reliability Program (PRP)

d. Medical record functions.
(1) Used for medical evaluation to determine medical and mental fitness.
(2) Screened periodically for all perconnel assigned to the PRP.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Segregate Health Records (HRECs) for personnel enrolled in the PRP.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 17: Personnel Reliability Program (PRP)

a. Ensure records are maintained under continuing evaluation.
b. Establish a cross reference system to account for the absence of these records from the central files.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Ensure the chain of custody in the handling of PRP records is not broken.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 18: Personnel Reliability Program (PRP)

a. Sign out the records during the duty day.
b. Ensure the PRP record is returned before the close of business the same duty day.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Label PRP records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 19: Personnel Reliability Program (PRP)

a. Mark the PRP block on the record folder to indicate participation in the program.
b. File DA Form 3180-R (Personnel Screening and Evaluation Record) as the top document on the left side of the folder in DA Form 3444 series jackes and directly under the DA Form 4515 in the 8005.
c. File DA Form 4515 (Personnel Reliability Program Record Identifier) as the top document on the right side of the folder in DA Form 3444 series jackets and top document of part II of DA Form 8005 series jacket.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Screen PRP records upon transfer.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 20: Personnel Reliability Program (PRP)

a. Ensure the gaining and loosing MTFs screen the PRP record per AR 50-5 or AR 50-6.
b. Annotate the SF 600 with "Preceding entries screened under provisions of AR 50-5 (or AR 50-6)" followed by the screener's printed name, grade and signature.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Forward medical records and loose documents to the proper custodian of the medical records.
CONDITIONS:	Given AR 40-66, medical records, and loose documents.
STANDARDS:	The soldier must forward medical records and loose documents to the proper custodian IAW AR 40-66.

1. Learning Step / Activity 1. Screen the records or documents against the MTF files.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 21: Screen Records or Documents

a. When a soldier out-processes, the Medical Treatment Facility (MTF) will record the new record custodian and cross reference charge-out folders, log books, etc., so that any late arriving records/documents can be forwarded to the current custodian
b. Identified files (files matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will name the member's assigned unit.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Determine the proper custodian.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 22: Screen Records or Documents

a. If possible, access the Defense Enrollment Eligibility Reporting System (DEERS) to determine the current custodian.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Forward list of members to servicing MILPO (military personnel office)/post locator.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 23: Forward List to MILPO/Post Locator

a. Include full name, SSN, and unit of assignment (if possible).
b. Attach a cover letter requesting the names be checked.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Forward the records/forms to the current custodian provided by the MILPO.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 24: Forward Records/Forms to Custodian

a. If the MILPO or post locator cannot find the address of the proper custodian forward the documents to the custodian as shown in the rules outlined in AR 40-66, paragraphs 5-26 d (3) (a) through (f).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Dispose of unidentifiable medical records and forms.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must dispose of unidentifiable records and forms IAW AR 40-66.

1. Learning Step / Activity 1. Dispose of unidentifiable medical records and forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 25: Dispose of Unidentifiable Records

a. Prepare a report listing the types of documents or records (for example, laboratory form; x-ray reports;
(SF 600, and so on) and the number of each type to be destroyed.
b. Obtain the patient administrator's signature on the report.
c. Forward the report to the MTF committee that audits medical records.
d. Upon the committee's approval, destroy the unidentifiable records and forms.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Transfer a Health Record (HREC)/Outpatient Treatment Record (OTR).
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must transfer a HREC/OTR IAW AR 40-66.

1. Learning Step / Activity 1. Disposition of Army health records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 26: Disposition of Health Records

a. Change of station (PCS): records (health and dental) are hand carried by the soldier.

NOTE: The losing custodian may send the soldier's records directly to the commander of the gaining MTF if he feels the records should not be hand carried.

Slide S HPABG024 27: Disposition of Health Records

b. Separation from the service: the records are forwarded to the military personnel officer overseeing the separation.
c. AWOL (over 10 days): the records are forwarded to the officer holding the soldier's military personnel records.
d. Death: the records are forwarded to the office holding the patient's personnel records.

Slide S HPABG024 28: Disposition of Health Records

e. Retirement of the service member:
(1) Normal retirement: the records are forwarded to the military personnel officer overseeing the retirement.
(2) Possible VA compensation: the records are forwarded to the VA regional office nearest patient's place of retirement.
(3) VA hospitalization: the records are forwarded to the VA hospital where the patient is hospitalized.

Slide S HPABG024 29: Disposition of Health Records

f. Maintenance of health records during combat conditions:
(1) The personnel officer will file the records with the service member's military personnel records.
(2) Forms received from a MTF (aid stations, clearing stations, etc.) will be filed in the records.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Tranferring the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 30: Transfer of Health Records

a. Both parts (health and dental) will be transferred (may be hand carried) when the service member's military personnel record is transferred.
b. The Personnel Officer of the gaining unit will receive the records from their custodian.

Slide S HPABG024 31: Transfer of Health Records

c. Exception:
(1) When the losing and gaining units receive their primary care from the same MTFs and DTFs.
(2) When an inpatient is assigned to a medical holding unit that already has the records.
(3) When the losing unit sends the records directly to the gaining unit.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

F. ENABLING LEARNING OBJECTIVE F

ACTION:	Dispose of an HREC.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must dispose of a HREC IAW AR 40-66.

1. Learning Step / Activity 1. Determine the type of separation.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 32: Type of Separation

a. Separating from the service.
b. Death .
c. Normal retirement.
d. Retirement with possible Veterans Affairs (VA) compensation.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Forwarding the HREC to the appropriate office.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 33: Forwarding the HREC

a. For a soldier separating from the service, forward the record to the military personnel officer handling the separation.
b. For death of the soldier, forward the record to the office holding the patient's personnel records.

Slide S HPABG024 34: Forwarding the HREC

c. For normal retirement, forward the record to the officer handling the separation.
d. For retirement with possible Veterans Affairs (VA) compensation, forward the record to the VA regional office nearest the patient's place of retirement.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

G. ENABLING LEARNING OBJECTIVE G

ACTION:	Retire an Outpatient Treatment Record (OTR).
CONDITIONS:	Given AR 40-66, AR 25-400-2, DA Form 3444-Series Folder, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must retire an OTR IAW AR 40-66 and AR 25-400-2.

1. Learning Step / Activity 1. Prepare the records for retirement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: Peer instruction

Slide S HPABG024 35: Prepare Records for Retirement

Note: Records shall be maintained for 3 years after the end of the year in which last medical treatment was given.

Slide S HPABG024 36: Prepare Records for Retirement

a. Determine the appropriate year that the OTR will be retired 3 years after the end of the year that the last medical treatment was given.
b. Retrieve the outpatient records for retirement from the OTR files.

c. Segregate the records based on the Modern Army Recordkeeping System (MARKS) file number (retired military, civilian, etc.).

Slide S HPABG024 37: Prepare Records for Retirement

d. File the records for retirement, using the terminal digit filing system, in record shipping cartons.

(1) Record the first and last record, MARKS file number, and carton series (1 of 12; 2 of 12, etc.) on each carton.
(2) Prepare a letter of transmittal for each shipment, segregated by MARKS file numbers.

Slide S HPABG024 38: Prepare Records for Retirement

e. Forward all letter(s) of transmittal to the National Personnel Records Center for their acceptance and issuance of
accession numbers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Transfer the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 39: Transfer the Records

a. Receive the accession numbers.
b. Forward the retired records to: National Personnel Records Center, 9700 Page Blvd, St. Louis, MO 63132.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

H. ENABLING LEARNING OBJECTIVE H

ACTION:	Retire an Inpatient Treatment Record (ITR)/Ambulatory Procedure Visit (APV)/Observation Record.
CONDITIONS:	Given AR 40-66 , AR 25-400-2, and DA Form 3444-Series Folder.
STANDARDS:	The soldier must retire an ITR/APV/Observation Record IAW AR 40-66 and AR 25-400-2.

1. Learning Step / Activity 1. Prepare the records for retirement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 40: Prepare the Records

a. Determine the appropriate year that the ITR will be retired.
(1) Maintain the records for teaching facilities for 5 years after the end of the year that the last medical treatment was given.
(2) Maintain the records for the U.S. Military Academy for 3 years after the end of the year that the last medical treatment was given.

Slide S HPABG024 40A: Prepare the Records

(3) Non-teaching hospital 1 year after the end of the year that the last medical treatment was given.

Slide S HPABG024 41: Prepare the Records

b. Retrieve the outpatient records for retirement from the OTR files.
c. Segregate the records based on the Modern Army Recordkeeping System (MARKS) file number (retired military, civilian, etc.).

Slide S HPABG024 42: Prepare the Records

d. File the records for retirement, using the terminal digit filing system, in record shipping cartons.
(1) Record the first and last record, MARKS file number, and carton series (1 of 12; 2 of 12, etc.) on each carton.
(2) Prepare a letter of transmittal for each shipment, segregated by MARKS file numbers.

Slide S HPABG024 43: Prepare the Records

e. Forward all letter(s) of transmittal to the National Personnel Records Center for their acceptance and issuance of
accession numbers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Transfer the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 44: Transfer the Records

a. Receive the accession numbers.
b. Forward the retired records to: National Personnel Records Center, 9700 Page Blvd, St. Louis, MO 63132.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

I. ENABLING LEARNING OBJECTIVE I

ACTION:	Operate a Record Control Program.
CONDITIONS:	Given AR 40-66 and HSC Pam 40-7-5.
STANDARDS:	The soldier must operate a Record Control Program IAW AR 40-66 and HSC Pam 40-7-5.

1. Learning Step / Activity 1. Initiation of Record Control.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 45: Operate a Record Control Program

a. Record Control begins when records are released from the files for use in clinic visits, physical examinations, scheduled therapy or consultation, administrative reviews, etc..
b. Records must be accounted for.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Accounting for record removal.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 46: Operate a Record Control Program

a. Upon removal of record a chargeout device should replace the record on the shelf.
b. Chargeout devices consist of "chargeout guides", in a series of five colors, and a chargeout card.

Slide S HPABG024 47: Operate a Record Control Program

c. Chargeout card contains:
(1) patient identification data.
(2) date and reason the record is charged out.
(3) individual's name or clinic to whom the record is released.
d. Card is inserted into the clear plastic pocket of the chargeout guide.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Seven (7) day chargeout policy procedures.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 48: Operate a Record Control Program

a. Medical command policy for return of charged out records is 7 days.

NOTE: MTFs are encouraged to establish a shorter record return policy locally when feasible for additional control.

b. Seven day charge out monitoring uses a 5 color outguide system.
(1) The same color outguide is used for every record charged out for, any reason, during a 7-day period of time, beginning on a Saturday and ending on the following Friday.

Slide S HPABG024 49: Operate a Record Control Program

(2) The following Saturday another color of outguide is used, and so on, until four colors of the outguides have been used (white excluded).
(3) The system provides up to 4 weeks for follow up on records that have not returned to the records room.

Slide S HPABG024 50: Operate a Record Control Program

(4) After 4 weeks, colored outguides from the first week that still remain in the files will be replaced by "white" outguides, annotated with the date.
(5) Saturday of the 5th week, the sequence of use of the colored outguides will be repeated.

Slide S HPABG024 51: Operate a Record Control Program

c. Each Monday, outguides from the previous week, still in the files, must be reviewed and appropriate follow up action initiated.
d. During the first Monday review, if it is determined that a record will not be returned during the next 3 weeks, the colored outguide shall be replaced by a white one, and the charge out card should be annotated with the date and the reason a longer charge out period has been recognized.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Chargeout cards in the outguide system.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 52: Operate a Record Control Program

a. Chargeout cards must be used in conjunction with the outguide system.
b. Chargeout cards must be accurately and legibly recorded with initial information.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Change of custodianship.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 53: Operate a Record Control Program

a. Occurs after the record has been charged out.
b. Requires the record room be notified of the new custodian.

Slide S HPABG024 54: Operate a Record Control Program

c. Procedure for documentation:
(1) Provide a duplicate charge out card with the record when it is originally charged out.
(2) When a custodian releases the record to another custodian, the card may be annotated and return to the records room, tracking the record.
(3) Records room inserts the card in the pocket of the chargeout guide.

Slide S HPABG024 55: Operate a Record Control Program

d. Two advantages of this method:
(1) It eliminates the need for the clinics to maintain a supply of change-of-custody cards.
(2) It eliminates the time required to fill in a blank change-of-custody card.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Messenger service.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 56: Operate a Record Control Program

a. A messenger service should be establish to ensure timely serve to patients, physician, and other care providers and to maintain positive control of individual records.

Slide S HPABG024 57: Operate a Record Control Program

b. Duties of messengers should include:
    (1) Medical record delivery and pickup service to clinics.
    (2) Search for and retrieval of overdue records.
    (3) Maintenance of an overdue record log.
    (4) Liaison and/or coordination between the outpatient records room and the clinics.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson, you should have become most aware that many things are to be considered in the management of medical records. Everything from their assemblage to destruction has to be done in an orderly and well defined manner. We looked at how to maintain records, how to file, store, and retrieve them, how to dispose of them, how to retire them, how to transfer them, and not to be overlooked, how to operate a Record Control Program to track where they are at all times. If parents gave as much attention to their children, we would all be better off. As a result, it should be evident to you that your management of patient records is one of the most important aspects of you job. Your patient's health depends on it.

Check on Learning

Conduct a check on learning and summarize the lesson.

QUESTION: In the Record Control Program, when is the "white" outguide first used?
ANSWER: Usually at the beginning of the fifth week, but also when it becomes evident that a record will be out for over 3 weeks.

QUESTION: Who may conduct a review of medical records?
ANSWER: a medical officer, a physician's assistant, or other qualified individuals.

QUESTION: What is the purpose of the PRP?
ANSWER: (1) Provides guidelines for the Army to identify nuclear duty positions.
(2) Provides a means of assessing the reliability of individuals whom are being considered for assignment to nuclear duty positions.

QUESTION: What are some of the reasons for disqualification for the PRP?
ANSWER: (a) Alcohol abuse.
(b) Drug abuse.
(c) Any physical condition which may impair judgement.
(d) Lack of motivation.
(e) Negligence of duty.
(f) Punitive processes (Article 15 or Court Martial).

QUESTION: Who gets the health record for a soldier separating from the service

ANSWER: Military personnel officer handling the separation.

QUESTION: Who gets the health record for a soldier who is retiring?
ANSWER: Military personnel officer handling the separation.

QUESTION: Where are retired health records sent?

ANSWER: National Personnel Records Center

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records Management" and "Medical Records II". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PART F: DIAGNOSTIC/PROCEDURAL CODING

The Army developed a training program to educate personnel to convert medical terminology (diagnosis and/or medical procedure) into numerical format. These numerical codes are used for many reasons, including research, manpower, budget requirements, and billing. The materials address inpatient record coding and outpatient record coding, because the two methods use different methods and resources.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG002
TSP Title	Diagnostic/Procedural Coding
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP Contains

TABLE OF CONTENTS

HPABG002 version 1 / Diagnostic/Procedural Coding
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0146	Code a Procedure Using CPT4
081-866-0180	Code a Diagnosis or Administrative Data Using the CHCS

Academic Hours

The Academic hours required to teach this TSP are as follows:

	Distance Learning Hours/Methods
	14.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	14.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
HPABG034	Anatomy & Physiology
HPABG035	Medical Terminology

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification	01 Sep 1980	
CPT 4	Physicians' Current Procedural Terminology	01 Feb 1997	

Student Study Assignments

None

Instructor Requirements	One (1) MOS 71G Qualified Instructor.
Additional Personnel Requirements	None
Equipment Required for Instruction	**Name** / **Quantity** / **Expendable** None
Materials Required	Instructor Materials: ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Physicians' Current Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647 Student Materials: M-HPABG002, Student Handout ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Physicians' Current Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647
Classroom, Training Area, and Range Requirements	
Ammunition Requirements	**Name** / **Student Qty** / **Misc Qty** None
Instructional Guidance	**NOTE:** Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.
Proponent Lesson Plan Approvals	**Name** / **Rank** / **Position** / **Date**

SECTION II. INTRODUCTION

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:44
Time of Instruction: 14 hrs
Media: PRINT

Motivator

SHOW SLIDE S-HPABG002-01

Record coding allows you to convert medical terminology, in the form of a patient's diagnosis or procedure, into a numerical format. These codes are used for a variety of reasons including, research, manpower, budget requirements, and billing.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

It is important to note that two types of coding are done in medical treatment facilities, both types will be explained in this lesson. The two types are, Inpatient Record coding and Outpatient Record coding. In each case the reasons for coding the record are basically the same, however, the methods and resources used differ.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Assign an appropriate ICD-9-CM code.
CONDITIONS:	Given a DA Form 3647 or 3647-1 with the inpatient diagnosis and/or surgical procedure annotated in writing and ICD-9-CM.
STANDARDS:	The soldier must assign the code IAW ICD-9-CM.

1. Learning Step / Activity 1. General description of ICD-9-CM volumes

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-02

A. Volume 1 - tabular list of diseases and injuries (tabular meaning organized as a numerical table or list).

1. 17 chapters of main classifications

2. Types of conditions (i.e., infections, neoplasms) and anatomical systems (i.e., diseases of the digestive system)

B. Volume 2 - alphabetic index divided into sections

NOTE: Explain that volumes 1 and 2 compliment each other and will always be used as a set when coding diseases and injuries

1. Index to diseases

2. Table of drugs and chemicals

SHOW SLIDE S-HPABG002-03

C. Volume 3 - a tabular list and alphabetical index of procedures

1. Tabular List - first section, based on anatomy

2. Alphabetic Index - second section, used to locate main term/sub-term

NOTE: Never code procedures directly from the Alphabetic Index. After locating a code in the index, refer to that code in the Tabular List for important instructions.

SHOW SLIDE S-HPABG002-04

D. Conventions/Instructional Notations.

1. Abbreviations.

a. NOS - not otherwise specified (used only in volume 1).

Example: Lymphangitis, acute NOS, 682.9 (pg 459, vol 2; pg 573, vol 1).

b. NEC - not elsewhere classifiable. Term used in volumes 2 & 3 when coder lacks information necessary to code the term to a more specific category.

Example: Tobacco abuse, NEC, 305.10 (pg 714, vol 2; pg 233, vol 1).
Intra-abdominal arteriography, NEC, 88.47 (pg 308/256, vol 3).

SHOW SLIDE S-HPABG002-05

2. Punctuation.

a. ( ) - parentheses are used to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned (one common code).

Example: Syphilis, secondary, relapse (treated) (untreated), 091.7 (pg 701, vol 2).

b. [ ] - brackets are used to enclose synonyms, alternative wordings, or explanatory phrases.

Example: Neoplasm, bone, astragalus [talus], 170.8 (pg 497, vol 2; pg 101, vol 1).

SHOW SLIDE S-HPABG002-06

c. : - colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers which follow in order to make it assignable to a given category.

Example: Talipes: calcaneous, equinus; 754.79 (pg 669, vol 1).

SHOW SLIDE S-HPABG002-07

d. } - braces are used to enclose a series of terms, each of which is modified by the statement appearing at the right of the brace.

Example: Emphysema, (chronic), due to inhalation of chemical fumes and vapors, 506.4 (pg 269, vol 2; pg 423, vol 1).

SHOW SLIDE S-HPABG002-08

3. Instructional notations.

a. Includes: - this note appears immediately under a three-digit code title to further define, or give example of, the contents of the category.

b. Excludes: - terms following the word 'excludes' are to be coded elsewhere as indicated in each case

c. Note: - certain main terms are followed by "Note:" which is used to define terms and give coding instructions at the main 3-digit category.

d. Code also underlying disease: - this note requires that the underlying disease (etiology) be recorded first and the particular manifestation recorded secondarily. This note appears only in Volume 1 Diseases: Tabular List.

SHOW SLIDE S-HPABG002-09

e. Use additional code if desired: - this instruction is placed in the Tabular List in those categories where the coder may wish to add further information (by using additional code) to give a more complete picture of the diagnosis or procedure.

NOTE: Explain that when this note appears, ignore the 'if desired' and always use more than one code to accurately define the diagnosis.

Example: Polyneuropathy in Diabetes, 357.20 & 250.60 (pg 205, vol 2; pg 279 vol 1).

f. Section mark (see top of page xxiv, vol 1) - this symbol preceding a code denotes the placement of a footnote at the bottom of the page which is applicable to all subdivisions of that code.

Example: Delivery, malpresentation, NEC, 652.91 (pg 184, vol 2; pg 548, vol 1).

NOTE: The section mark appears preceding the major 3-digit category (652, Malposition and malpresentation of the fetus, pg 547, vol 1) therefore verification must always be taken back to the major 3-digit category in volume 1 to ensure no reference to a 5th digit requirement.

SHOW SLIDE S-HPABG002-10

4. Cross references.

a. See - an explicit direction to look elsewhere.

Example: Gastrointestinal - see condition (pg 329, vol 2).

b. See also - directs the coder to look under another main term if all the information being looked for cannot be located under the first.

Example: Gastroenteritis, acute (see also - enteritis) (pg 328, vol 2).

SHOW SLIDE S-HPABG002-11

5. Etiology and manifestation of disease - for certain conditions, it is important to record both the etiology (underlying cause) and the manifestation (significant conditions) of the disease as it is currently presented.

a. Apply a fifth digit code.

b. Both the etiology and the manifestation are coded individually (the Alphabetic Index will list both codes).

NOTE: You must trust the Alphabetic Index when you consult the Tabular List, especially since the term you locate in the index is not repeated in the Tabular List. Index guidance should always be followed unless the Tabular List gives instructions which specify otherwise.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Use the ICD-9-CM to code diagnoses and procedures

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

NOTE: Refer students to Volume 2. Explain that although the volumes are numbered, Volume 2 is always used first to begin the process of coding a disease or injury.

NOTE: Instruct students to turn to page 1, vol 2.

SHOW SLIDE S-HPABG002-12

A. Volume 2 - Index to Diseases

1. Main terms - bold print, arranged alphabetically.

a. May be the actual disease (cholecystitis, appendicitis)

b. May be the actual problem (failure, congestion, infarction, distress)

c. May never be an anatomical part or organ (heart, stomach) or a 'modifier' (acute, fetal, allergic)

2. Sub terms - normal print, indented, alphabetical order.

NOTE: Indention increases as diagnosis becomes more specific.

NOTE: Demonstrate the determination of main and sub terms (emphasize indentation) using the following diagnoses:
- Diaper rash (Rash, diaper, c-691.0, pg 620, vol 2).
- Chronic bronchitis (Bronchitis, chronic, c-491.9, pg 97, vol 2).
- Chronic bronchitis w/ airway obstruction (Bronchitis, chronic, with airway obstruction, c-491.2, pg 97, vol 2).

SHOW SLIDE S-HPABG002-13

3. Tables - used when a specific disease can be classified in more than one manner.

NOTE: Refer students to Vol 2, pg 375.

a. Hypertension - has a table following the main term. Classification columns used to identify malignant (life-threatening), benign (non-life threatening), and unspecified (not specified benign or malignant) conditions,

NOTE: Refer students to Vol 2, pg 494.

b. Neoplasms - table lists neoplasms by anatomic site, alphabetically. Columns used to further classify condition as:

1) Malignant - to include primary (cancer originated in that area first), secondary (cancer has metastasized to a second location), and carcinoma in situ (cancer has remained where it originated).

2) Benign - not malignant, not recurrent, favorable for recovery.

3) In situ - neoplasms undergoing malignant changes and still confined to the point of origin and have not yet invaded the surrounding normal tissue.

4) Uncertain behavior - ultimate behavior of neoplasm can not be determined or predicted, may undergo changes at a later date.

5) Unspecified nature - diagnosis not specifically stated by behavior or morphology and not noted as benign or malignant.

SHOW SLIDE S-HPABG002-14

B. Volume 2 - Table of Drugs and Chemicals

NOTE: Refer students to Vol 2, pg 763.

1. Contains a classification of drugs and other chemical substances to identify poisoning states and external causes (E codes) of adverse effects.

2. Department of the Army directs use of only column 1, Poisoning, and column 3, Therapeutic Use (adverse reaction).

NOTE: Therapeutic use refers to a correct substance properly administered in therapeutic or prophylactic dosage.

a. Only E codes E930 through E949 are used by the military.

NOTE: Have students determine the code for an adverse reaction to penicillin. (E930.0, pg 834, vol 2)

b. Other cause of injury codes come from Standard NATO Agreement 2050 (STANAG 2050).

NOTE: Explain that the military has its own unique injuries (combat and training injuries), therefore, it has its own injury codes.

SHOW SLIDE S-HPABG002-15

C. Volume 1 - Tabular List of Diseases and Injuries

NOTE: Have students turn to volume 1

1. Used to verify diagnostic code found in Volume 2.

NOTE: Explain that volume 1 may provide additional instructions or notes that would direct the use of a different code from that selected in volume 2.

SHOW SLIDE S-HPABG002-16

2. Structure.

a. Chapter - groups of three digit codes referring to a broad spectrum of diseases or injuries.

Example: Chapter 1, Infectious and parasitic diseases (001-139), pg 1, vol 1.

b. Sections - groups of three digit codes that narrow down the spectrum.

Example: Intestinal Infectious Diseases (001-009), pg 1, vol 1.

c. Categories - three digit codes that represent specific information about a disease or injury group.

Example: 008 Intestinal infections due to other organisms, pg 5, vol 1.

d. Subcategories - four digit codes that represent specific information about a disease or injury.

Example: 008.4 Other specified bacteria, pg 5, vol 1.

e. Sub-classifications - five digit codes that further define a specific type of disease.

Example: 008.42 Psuedomonas, pg 5, vol 1.

NOTE: Explain that therefore, the code 008.42 is an infectious or parasitic disease, specifically of the intestines, caused by an otherwise specified bacteria, specifically Psuedomonas.

NOTE: Refer students to pg 880, vol 1.

SHOW SLIDE S-HPABG002-17

3. Supplementary Classification, V-codes. Provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999, or to the E code, are recorded as "diagnoses" or "problems."

a. Person not currently sick encounters the health services for some specific purpose:

1) To act as an organ donor.

Example: V59.4, Donor, kidney; (pg 912, vol 1 (pg 251, vol 2)).

2) To receive a prophylactic vaccination.

Example: V04.1, Vaccination, smallpox; (pg 883, vol 1 (pg 741, vol 2)).

b. A circumstance or problem is present which influences the person's health status but is not itself a current illness or injury. An example is a personal history of certain diseases.

NOTE: Explain that in these circumstances the V code should only be used as a supplementary code and should not be the one selected for use in primary, single cause tabulations.

Example: V01.1, contact with or exposure to tuberculosis; (pg 880, vol 1 (pg 286, vol 2)).

SHOW SLIDE S-HPABG002-18

D. Volume 3 - Tabular List and Alphabetic Index of Procedures

1. Tabular List.

a. Similar to the Tabular List found in Volume 1.

b. Contains special instructions and notes relevant to the coding of procedures.

c. Used to verify procedure codes obtained from the Alphabetic Index.

2. Alphabetic Index.

a. Used first.

b. Locate main terms and sub-terms (modifiers).

NOTE: Never code directly from the Alphabetic Index. After locating a code in the index, refer to that code in the Tabular List for important instructions. These instructions are in the form of notes suggesting the use of additional codes, and exclusion notes which indicate the circumstances under which a procedure would be coded elsewhere.

Example: Appendectomy, incidental; 47.1, pg 307/131, vol 1.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Complete the required fields of a DA Form 3647.
CONDITIONS:	Given a DA Form 3647, the IPDS User's Manual, a DA Form 2985, AR 40-66, and AR 40-400.
STANDARDS:	The soldier must complete the required fields IAW AR 40-66, AR 40-400, and IPDS User's Manual.

1. Learning Step / Activity 1. Purpose/preparation of DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-19

A. Purpose of Inpatient Record Cover Sheet (DA Form 3647/3647-1).

1. Provides administrative and medical summary of each inpatient episode.

2. An essential document for a Health Record, Outpatient Record, and ITR.

3. Source document for statistical information.

B. Prepared by:

1. All hospitals.

2. Fixed troop clinics.

3. Convalescent centers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Reasons for preparation and distribution or DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-20

A. Prepared for:

1. All admissions (for bed care).

2. Liveborn (not prepared for still births).

3. Carded for Record Only (CRO).

a. Death (DOA at your facility).

b. Disability separation/retirement (Medical Boards processed on an outpatient basis.

c. Selected conditions of medico-legal significance (to provide a record for MTF, i.e., rape or assault cases).

SHOW SLIDE S-HPABG002-21

B. Distribution of DA Form 3647.

1. Original and worksheet - Inpatient Treatment Record.

2. 1 copy - Health Record or Outpatient Record as applicable.

NOTE: Need for extra copies may vary depending on MTF policy.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Completing the DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

NOTE: Explain that items 1-24, 27-30, and 33 are completed at the time of admission.

SHOW SLIDE S-HPABG002-22

A. Item 25 - Type of Disposition.

1. Duty - active duty personnel only.

2. Transfer - any category of patient.

    a. Enter "TAR" if transferred to Army MTF.

    b. Enter "TAF" if transferred to Air Force MTF.

    c. Enter "TNV" if transferred to Navy MTF.

    d. Entry must begin in Item 25 and continued in Item 31, stating the name of the facility the patient was transferred out to.

3. Separation/retirement under provisions of AR 635-40 or AR 635-200.

    a. Enter "PDRL" or "TDRL" AR 635-40 (Permanent or Temporary Disability Retirement).

    b. Separation and action taken (i.e., severance pay), for AR 635-200 separations.

4. Discharged - non-active duty patients.

5. Death (hospital, CRO, neonatal, or maternal).

    a. Enter "Died" or "Expired."

    b. Continue in Item 31 whether an autopsy was done (i.e., "Autopsy Yes" or "Autopsy No").

SHOW SLIDE S-HPABG002-23

B. Item 26 - Date of disposition.

1. DD MMM YY - This will be the date the patient's name appeared on the AAD report as a disposition.

2. CRO records - date of disposition is same as date of admission (Item 28).

SHOW SLIDE S-HPABG002-24

C. Item 31 - Administrative data.

1. Medical and Physical Evaluation Boards.

    a. Enter type of board (MEB, PEB).

    b. Enter date of board.

    c. Enter recommendations made by board.

2. Absence of patient - enter dates from and to, enter total number of days in parentheses.

    a. Other days - total number of days spent in 'status-out' to :

        1) AWOL (more than 10 consecutive days only).

2) PCS home.

3) PCS VA.

4) Subsisting out.

5) TDY

6) Other authorized absence (i.e., leave).

b. Absent sick - enter hospital and dates from and to.

c. Supplemental care days - enter place and dates from and to.

d. Convalescent leave - enter dates from and to.

3. ASMRO (Armed Services Medical Regulating Office)

a. If patient was evacuated (coordinated through ASMRO), enter the ASMRO cite number authorizing the movement.

b. Enter the cite movement precedence (Urgent/Priority/Routine) and the name of the physician accepting the patient at the receiving MTF.

4. SI/VSI patients.

a. Enter a clear chronological outline of patient's status.

b. Show dates patient was placed on and taken off the SI/VSI roster.

NOTE: This is for progress reporting purposes and eliminates the need for the receiving MTF to search through the patient's record for this information.

5. Neonatal death.

a. Death of an infant under 28 days of age.

b. Enter the infant's age at death.

Example: Neonatal death age - 15 days.

NOTE: If the death occurred during the first 24-hours, enter the age in hours.

6. Change of status date.

Example: Newborn to pay status when the infant remains and the mother is discharged.

SHOW SLIDE S-HPABG002-25

D. Item 32 - Units of Whole Blood transfused.

1. Enter number of units (500cc = 1 unit)

2. If no blood transfused, leave blank.

SHOW SLIDE S-HPABG002-26

E. Item 33 - Cause of Injury.

1. Complete only for patients treated for injuries.

NOTE: The Type Case (Item 20) will be either INJ or BC for patients admitted with an injury. Injury occurring after admission (drug reaction, fall from bed, etc.) will require a cause of injury code and statement.

2. External cause of injury (specify poison, chemical reaction).

3. Circumstances and activity - how the injury occurred.

a. Action against enemy.

b. Activity (patient's actions).

1) Accidentally incurred (rifle accidentally discharged while cleaning).

2) Deliberately incurred.

a) Inflicted by another person.

b) Self-inflicted to avoid duties or as an act of the mentally unsound (suicide or attempted suicide).

c. Motor vehicle accident.

1) Enter type of vehicle (car, bus, truck).

2) Enter ownership of vehicle (POV, GOV).

d. Location (place).

1) On post (barracks, mess hall, etc.).

2) Off post (state specific location).

e. Date and time of injury.

f. Duty status of military member at time of injury.

1) Engaged in assigned duties and their nature.

2) AWOL.

3) Pass.

4) Leave.

NOTE: This information is important for Medical Affirmative Claims, Line of Duty investigations, and Medical Evaluation Boards.

SHOW SLIDE S-HPABG002-27

F. Item 34 - Diagnoses and Operations.

1. Diagnoses.

a. Number consecutively when recording more than one diagnosis.

1) Enter the principle diagnosis first when more than one diagnosis exists.

NOTE: Principle diagnosis determination is the responsibility of the physician. This diagnosis is established after study to be chiefly responsible for this admission. Do not record diagnoses from past admissions, status post conditions, or physical findings that have no bearing on the current period of treatment.

2) For patients whose entire episode was in Absent Sick status, all diagnoses treated and procedures performed will be entered by the recording MTF.

b. Enter code number to left of medical terminology.

c. Enter diagnosis in medical terminology.

d. Enter any additional administrative information needed to fully define the diagnosis.

1) Enter "EPTS" if the diagnosis existed prior to service.

2) Enter "PR" if the condition relates to a previously treated condition (active duty patients only), then enter date and place.

Example: 493.90 Asthma (PR WRAMC WASH DC Jan 98)

3) Document Residual Disability (include body part).

NOTE: This applies to an injury causing separation or retirement determined during the current hospital stay.

Example: Limb amputation - duty impairment.

4) Document Death information.

a) Diagnosis determined after death will be identified as "Established Post Mortem."

b) Suicide, homicide, or legal execution.

c) Enter "Underlying Cause" of death if applicable.

e. Deliveries (Mother's Record).

1) Presentation of fetus (breech, face, etc.).

2) Liveborn or stillbirth.

3) Duration of pregnancy in weeks.

4) Previous cesarean section (if any).

5) If still birth cause of fetal death and birthweight must be recorded on mother's record.

NOTE: Information required for a stillbirth is part of the mother's record. A separate record is not made for the stillborn child.

2. Operations/Procedures.

a. Enter date procedure took place.

b. Enter principal procedure code.

NOTE: The principal procedure determination is the responsibility of the physician. This procedure is the one performed for definitive treatment most closely related to the principal diagnosis (removal of cancer of the tongue), rather than for diagnostic biopsy or exploratory purposes; or, to treat a complication such as a fall necessitating surgical fixation of a broken hip; or most tissue removed; or tests done for the procedure most related to the principal diagnosis or a therapeutic procedure.

c. Enter procedural terminology.

SHOW SLIDE S-HPABG002-28

G. Item 35 - Total Days this Facility.

NOTE: This item refers to the medical treatment facility where the coversheet is being completed.

SHOW SLIDE S-HPABG002-29

1. Item 35a - Absent Sick days.

a. Cross reference Item 31 for number of days.

b. No days recorded in Item 31, leave Item 35a blank.

SHOW SLIDE S-HPABG002-30

2. Item 35b - Other days.

NOTE: This could relate to a patient en route from one facility to another, AWOL, PCS home, PCS VA, TDY, or other authorized absence, but out-of-the-bed at government cost (active duty).

SHOW SLIDE S-HPABG002-31

3. Item 35c - Convalescent Leave/Cooperative Care days.

a. Cross reference Item 31.

b. If no Conv Lv/Coop Care, leave blank.

SHOW SLIDE S-HPABG002-32

4. Item 35d - Supplemental Care days.

NOTE: Patients must be in Status-Out receiving care or having a need for equipment at another facility during hospitalization.

a. Cross Reference Item 31.

b. If no supplemental care days, leave blank.

SHOW SLIDE S-HPABG002-33

5. Item 35f - Total Sick days.

NOTE: It is necessary to know the total sick days before Bed days (Item 35e) can be calculated.

a. Subtract date of this admission from the date of disposition (use Julian dates).

b. Verify that the total number of days (35f) is equal to the sum of 35a thru 35e.

c. Absent sick patients: subtract date of initial admission from disposition date.

SHOW SLIDE S-HPABG002-34

6. Item 35e - Bed days.

a. Days recorded in 35a thru 35d are not bed days.

b. Days occupying a bed or bassinet.

c. Enter 0 in Item 35f for CRO or total absent sick patients.

SHOW SLIDE S-HPABG002-35

H. Item 36 - Total Days All Facilities.

NOTE: This is used for Transfer Admissions only. Verify this from Item 21, Source of Admission.

1. Summation of all transfer ITRCS days.

2. Leave blank for direct admissions.

3. Subtract date of initial admission from date of disposition.

a. Item 36a - Absent sick days.

b. Item 36b - Other days.

c. Item 36c - Con Lv/Coop Care days.

d. Item 36d - Supplemental Care days.

e. Item 36e - Bed days.

f. Item 36f - Total sick days.

NOTE: Days to be recorded in Item 36a thru 36f can be determined by cross referencing Item 31 of all ITRCS received from other facilities.

SHOW SLIDE S-HPABG002-36

I. Signature blocks are typed as required.

1. Attending physician, dentist, podiatrist, or midwife will sign worksheet copy.

2. Signature of attending physician is not required on CRO cases (patient did not occupy bed).

3. Patient or Medical Record Administrator (name, grade, corps - all caps).

a. Signs all completed ITRCS.

b. Only signature required for CRO and DOA cases.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Assign an appropriate CPT4 code.
CONDITIONS:	Given an Ambulatory Data System (ADS) encounter form with the diagnosis and/or ambulatory procedure annotated in writing and CPT4.
STANDARDS:	The soldier must assign the code IAW CPT4.

1. Learning Step / Activity 1. Describe the use of CPT codes.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-37 (Show this slide while discussing the ELO Title)

SHOW SLIDE S-HPABG002-38

A. Description. Current Procedural Terminology (CPT) is a systematic listing of procedures and services performed by physicians. Each procedure or service is identified by a five digit code.

1. Provides a uniform language that accurately describes medical, surgical and diagnostic services.

2. Provides reliable communication between physicians, patients and third parties.

SHOW SLIDE S-HPABG002-39

B. Use.

NOTE: CPT Codes are used to report outpatient procedures and services **only**.

1. Insurance billing for procedures and services provided.

2. Administrative management purposes (i.e., claims processing).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Describe the format of the CPT book.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-40

A. The Physician's Current Procedural Terminology (CPT) is divided into three main parts.

1. Main Text.

2. Appendices.

3. Alphabetic Index.

SHOW SLIDE S-HPABG002-41

B. Main Text.

1. Divided into six sections.

a. Evaluation and Management.

NOTE: Items in this section will be used by most physicians to report a significant portion of their services.

b. Anesthesiology.

c. Surgery.

d. Radiology (including Nuclear Medicine and Diagnostic Ultrasound).

e. Pathology and Laboratory.

f. Medicine.

NOTE: Listing a service or procedure and it's code number in a specific section of the book does not limit it's use to a specific specialty group. Any procedure or service in any section of the book may be performed by any qualified individual.

SHOW SLIDE S-HPABG002-43

2. Subsections. Divide main sections and contain anatomic, procedural, condition or descriptor subheadings.

Example: pg 127, Respiratory (main section), Nose (subsection), Incision (procedural subheading).

3. Format of CPT procedure terminology.

a. Developed as stand-alone descriptions of medical procedures.

b. Some procedures refer back to a common portion of the procedure listed in a preceding entry. This is evident when a procedure is followed by one or more indentations.

Example: pg 95, 25105 Arthrotomy, wrist joint; for synovectomy

NOTE: The common part of code 25100 (the part before the semicolon) should be considered part of code 25105.

SHOW SLIDE S-HPABG002-44

C. Four Appendices.

1. Appendix A - Modifiers. Contains a list of all modifiers applicable to CPT codes.

NOTE: Explain that modifiers are used to indicate a service or procedure that has been performed has been altered by some specific circumstance but has not been changed in its definition or code.

2. Appendix B - Summary of Additions, Deletions or Revisions.

3. Appendix C - Update to Short Descriptors. Used to update electronic (digital) CPT data file.

4. Appendix D - Clinical Examples Supplement. Provides examples of clinical encounters with patients that would be coded under the Evaluation and Management section of the CPT.

NOTE: The examples contained in Appendix D are not to be used to code the encounter.

SHOW SLIDE S-HPABG002-45

D. Index.

1. Main Terms. The index is organized by main terms arranged alphabetically in 4-primary classes.

a. Procedure or service.

Example: Endoscopy, Anastomosis; Splint.

b. Organ (or other anatomic site).

Example: Tibia; Colon; Salivary Gland.

c. Condition.

Example: Abcess; Entropian; Tetralogy of Fallot.

d. Synonyms, Eponyms, and Abbreviations.

Example: EEG; Bricker Operation; Clagett Procedure.

SHOW SLIDE S-HPABG002-46

2. Conventions.

a. Modifying Terms.

1) Indented.

2) Up to 3 may follow main term.

NOTE: When modifying sub-terms appear, review list. Sub-terms effect selection of appropriate code.

b. Code Ranges.

1) Used whenever more than one code applies.

2) Two sequential or several non-sequential, separated by comma.

Example: pg 432, 69220, 69222; Debridement, Mastoid Cavity

3) More that two sequential, separated by hyphen.

Example: pg 407, 86060-86063; Antibody, Antistreptolysin 0.

SHOW SLIDE S-HPABG002-47

c. Cross References.

1) See: - Directs the coder to the term listed after the word "See." Used primarily for synonyms, eponyms, and abbreviations.

2) See Also: - Directs the coder to look under another main term if the procedure is not listed under the first main term entry.

NOTE: The index is **not** a substitute for the main text of CPT. The user must refer to the main text to ensure accurate code selection.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Describe the ADS encounter form.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-48

A. General.

1. Backbone of the Ambulatory Data System (ADS).

NOTE: The ADS is a system by which detailed, patient-level information on outpatient care provided by the Military Health Services System (MHSS) is collected.

2. "Bubble Sheet" - similar to those used when taking a test.

3. Prepared in advance for all patients with scheduled appointments.

B. Sections.

SHOW SLIDE S-HPABG002-49

1. Front side.

a. ICD-9-CM Diagnoses - a pick list of diagnoses most common to the clinic.

NOTE: The diagnoses listed in this section will vary from clinic to clinic based on the type of medicine practiced.

b. Evaluation & Management.

1) Correlates to E&M section of CPT Manual.
2) Lists most common E&M codes for the clinic.

SHOW SLIDE S-HPABG002-50

c. Disposition.

d. Administrative.

e. Appointment Status.

SHOW SLIDE S-HPABG002-51

f. CPT Procedures - lists the most common procedures performed in the clinic.

NOTE: The procedures listed in this section will vary from clinic to clinic based on the type of medicine practiced.

g. Patient identification/demographic information.

SHOW SLIDE S-HPABG002-52

2. Back side.

a. Other Diagnoses - space for entering up to three diagnoses, and CPT codes, that are not contained in the pick list on the front of the form.

b. Other Procedures/E&M - space for entering up to three procedures or E&M descriptions, and the correlating codes, that are not listed on the front of the form.

c. Other information.

1) Third party insurance information.
2) Provider/additional provider information.
3) Patient demographic changes.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Code a diagnosis or procedure in an outpatient record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-53

NOTE: As stated earlier, the most common procedures performed in the clinic will be noted in the pick list on the front of the ADS encounter form. However, for our purposes we will assume that the diagnosis and procedure are annotated on the back of the form, and need to be coded.

SHOW SLIDE S-HPABG002-54

Scenario: A patient is seen in the clinic for a dressing change and debridement with anesthesia of a 3rd degree burn suffered to the forearm and hand (less than 9% BSA, full thickness). (ICD-9-CM, V58.3; Aftercare, change of dressings)
(E&M, 99214)

NOTE: The Evaluation and Management (E&M) code is required for all patients. The healthcare provider is held accountable for this code and must attest to its accuracy.

SHOW SLIDE S-HPABG002-55

A. Code the diagnosis, using the ICD-9-CM, IAW the method described previously.

B. Locate the code for the procedure in the CPT manual.

1. Using the main text.

SHOW SLIDE S-HPABG002-56

a. Carefully read the description of the procedure from the clinical documentation provided - dressing change and debridement with anesthesia, forearm and hand.

SHOW SLIDE S-HPABG002-57

b. Determine which section of the main text to look in (i.e., Surgery, Anesthesia, etc.). Carefully read the guidelines for that section.

Example: Surgery

1) Determine the appropriate subdivision (body region or system).
Example: Integumentary, Repair, Burns, Local Treatment

2) Determine the appropriate code for the procedure or service.
Example: 16015, Dressings and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement.

SHOW SLIDE S-HPABG002-58

2. Using the index.

a. The index is an alphabetic listing of anatomical locations/regions, body systems, procedures and services.

b. Locate procedure or service and note the code to the right.

NOTE: Do not assign the code based solely on the listing in the index.

c. Refer to the main text for a detailed description of the procedure or service and assign the appropriate code as explained above.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:44
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

SHOW SLIDE S-HPABG002-59

During this lesson we have discussed the methods used to convert the medical terminology used in describing a patient's diagnosis and the treatment (procedures/services) received by the patient, into standardized numerical codes.

We have discussed the ICD-9-CM, used to code Inpatient Records; and the Inpatient Treatment Record Coversheet, which becomes the source document for any possible billing for inpatient treatment and/or statistical applications. And, we have discussed the use of Current Procedural Terminology (CPT) to code outpatient records.

It is important to remember, that although procedures and services are provided to both inpatients and outpatients in the MTF, these procedures and services are coded differently based on the patient's status (in/outpatient).

Check on Learning

Conduct a check on learning and summarize the lesson.

SECTION V. STUDENT EVALUATION

Testing Requirements	**NOTE:** Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.
Feedback Requirement	**NOTE:** Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

PRACTICAL EXERCISE SHEET PE1-HPABG002

Title	Assign a CPT4 Code
Lesson Number/Title	HPABG002 version 1 / Diagnostic/Procedural Coding
Introduction	
Motivator	

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements	
Risk Assessment Level	Low
Environmental Considerations	
Evaluation	
Instructional Lead-In	

Resource Requirements	Instructor Materials: Student Materials: M-HPABG002, Student Handout ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Common Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647
Special Instructions	
Procedures	
Feedback Requirements	

PRACTICAL EXERCISE SHEET PE2-HPABG002

Title

Assign an ICD-9-CM Code

Lesson Number/Title

HPABG002 version 1 / Diagnostic/Procedural Coding

Introduction

Motivator

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

Risk Assessment Level

Low

Environmental Considerations

Evaluation

Instructional Lead-In

Resource Requirements

Instructor Materials:

Student Materials:

M-HPABG002, Student Handout
ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification
CPT4, Current Procedural Terminology, 4th Revision
PE2-HPABG002, Assign an ICD-9-CM Code

Special Instructions

Procedures

Using Volumes 1, 2, & 3 of ICD-9-CM, code the following inpatient diagnoses and procedures IAW the methods discussed in the lesson.

Working with Main Terms

Annotate the volume number, page number(s), and code for each of the following:

1. Obesity
2. Low back pain
3. Hepatitis
4. Viral Syndrome
5. Acute diarrhea
6. Juvenile diabetes (controlled)
7. Painful respiration
8. Upward gaze syndrome
9. Inflammatory diarrhea due to specified organism NEC
10. Diabetic ketosis, juvenile type
11. Chronic childhood schizophrenia
12. Periostitis of the wrist

Working with Injuries

13. Third degree burns, multiple sites of the trunk
14. Sprain of the tibia, distal end
15. Gunshot wound to the chest wall, complicated
16. Cervical spinal (cord) injury, level C5-C7

17. Nonvenomous insect bite, to the left index finger, infected

18. Traumatic amputation of the right leg, above the knee

19 Stabbing wound to thigh, with injury to femoral artery

20. Stellate lacerations of the liver

21. Closed fracture of second cervical vertebra

22. Open wound, multiple sites of upper limb, with tendon involvement

Working with External Causes of Injury Codes - E Codes

Remember, not all "E Codes" are preceded by the "E" character. Use only the poisoning and therapeutic columns.

WHAT IS THE PROBLEM? WHAT CAUSED THE PROBLEM? WAS IT A POISONING OR AN ADVERSE REACTION (THERAPUTIC USE)?

23. Tachycardia, due to adverse reaction to Benadryl

24. Charcoal fumes poisoning

25. Inflammation of the throat due to rubbing alcohol ingestion

26. Toxic gastroenteritis and colitis due to soap powder poisoning

27. Superficial skin swelling due to tetanus toxoid vaccination

Working with Dual Codes

28. Hepatitis due to malaria

29. Diabetic neuralgia (adult onset)

30. Rheumatic pneumonia

31. Abscess of the epididymis due to streptococcus bacteria infection

32. Neoplasm of the esophagus primary, with metastasis to the larynx secondary

Miscellaneous

33. Carcinoma of the brain, frontal lobe

34. Hypertension due to kidney calculus, benign

35. Psychosexual dysfunction with frigidity

36. Vitamin D deficiency with rickets

37. Postoperative hernia with obstruction

38. Foreign body inadvertently left in operative wound, causing adhesions

39. Acute gastritis with hemorrhage

40. Otitis Media, Acute, mucoid

41. Chronic gonoccal prostatitis

42. Labor, undelivered

Working with V-Codes

43. Artificial insemination

44. Family history of leukemia

45. Holiday relief care

46. Bone marrow donor

47. Admission for adjustment of artificial eye

48. Traction maintenance, NEC

49. Marital adjustment involving estrangement

50. Admission for sterilization, male

51. Prophylactic smallpox vaccination

PROCEDURES

Working with Main Terms

52. X-ray of the chest wall
53. Plasma transfusion
54. Tenotomy of the stapedius
55. Total resection of the esophagus
56. Steinberg operation
57. Exploratory pelvic laparotomy
58. Repair of lacerated liver
59. Hypodermic injection of therapeutic agent into the bursa of the hand
60. Removal of foreign body from the nailbed, left thumb
61. Mid-forceps delivery, with episiotomy
62. Correction of lop ear
63. Face lift
64. Electrocoagulation of cervical lesion
65. Biopsy of ocular muscle
66. Circulation time function study
67. Repair of open fracture of foot with internal fixation
68. Tenoplasty of left hand by implant
69. Removal of impacted feces
70. Corneal irrigation with removal of foreign body
71. Replacement of nasogastric tube
72. Application of fiberglass cast to upper limb

73. Reinsertion of internal fixation device of the fibula
74. Umbilical herniorrhaphy
75. Thrombectomy of a femoral vein
76. Root canal with irrigation

Working with Dual Coded Procedures

77. Partial esophagectomy with thoracic esophagostomy
78. Laryngoscopy with biopsy
79. Reattachment of left thumb and right index finger
80. Fistulectomy of the small and large intestine

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

Using Volumes 1, 2, & 3 of ICD-9-CM, code the following inpatient diagnoses and procedures IAW the methods discussed in the lesson.

Working with Main Terms

Annotate the volume number, page number(s), and code for each of the following:

1. Obesity

2. Low back pain

3. Hepatitis

4. Viral Syndrome

5. Acute diarrhea

6. Juvenile diabetes (controlled)

7. Painful respiration

8. Upward gaze syndrome

9. Inflammatory diarrhea due to specified organism NEC

10. Diabetic ketosis, juvenile type

11. Chronic childhood schizophrenia

12. Periostitis of the wrist

Working with Injuries

13. Third degree burns, multiple sites of the trunk

14. Sprain of the tibia, distal end

15. Gunshot wound to the chest wall, complicated

16. Cervical spinal (cord) injury, level C5-C7

17. Nonvenomous insect bite, to the left index finger, infected

18. Traumatic amputation of the right leg, above the knee

19 Stabbing wound to thigh, with injury to femoral artery

20. Stellate lacerations of the liver

21. Closed fracture of second cervical vertebra

22. Open wound, multiple sites of upper limb, with tendon involvement

Working with External Causes of Injury Codes - E Codes

Remember, not all "E Codes" are preceded by the "E" character. Use only the poisoning and therapeutic columns.

WHAT IS THE PROBLEM? WHAT CAUSED THE PROBLEM? WAS IT A POISONING OR AN ADVERSE REACTION (THERAPUTIC USE)?

23. Tachycardia, due to adverse reaction to Benadryl

24. Charcoal fumes poisoning

25. Inflammation of the throat due to rubbing alcohol ingestion

26. Toxic gastroenteritis and colitis due to soap powder poisoning

27. Superficial skin swelling due to tetanus toxoid vaccination

Working with Dual Codes

28. Hepatitis due to malaria

29. Diabetic neuralgia (adult onset)

30. Rheumatic pneumonia

31. Abscess of the epididymis due to streptococcus bacteria infection

32. Neoplasm of the esophagus primary, with metastasis to the larynx secondary

Miscellaneous

33. Carcinoma of the brain, frontal lobe

34. Hypertension due to kidney calculus, benign
35. Psychosexual dysfunction with frigidity

36. Vitamin D deficiency with rickets

37. Postoperative hernia with obstruction

38. Foreign body inadvertently left in operative wound, causing adhesions

39. Acute gastritis with hemorrhage

40. Otitis Media, Acute, mucoid

41. Chronic gonoccal prostatitis

42. Labor, undelivered

Working with V-Codes

43. Artificial insemination
44. Family history of leukemia
45. Holiday relief care
46. Bone marrow donor
47. Admission for adjustment of artificial eye
48. Traction maintenance, NEC
49. Marital adjustment involving estrangement
50. Admission for sterilization, male
51. Prophylactic smallpox vaccination

PROCEDURES

Working with Main Terms

52. X-ray of the chest wall
53. Plasma transfusion
54. Tenotomy of the stapedius
55. Total resection of the esophagus
56. Steinberg operation
57. Exploratory pelvic laparotomy
58. Repair of lacerated liver
59. Hypodermic injection of therapeutic agent into the bursa of the hand
60. Removal of foreign body from the nailbed, left thumb
61. Mid-forceps delivery, with episiotomy
62. Correction of lop ear
63. Face lift
64. Electrocoagulation of cervical lesion
65. Biopsy of ocular muscle
66. Circulation time function study
67. Repair of open fracture of foot with internal fixation

68. Tenoplasty of left hand by implant
69. Removal of impacted feces
70. Corneal irrigation with removal of foreign body
71. Replacement of nasogastric tube
72. Application of fiberglass cast to upper limb
73. Reinsertion of internal fixation device of the fibula
74. Umbilical herniorrhaphy
75. Thrombectomy of a femoral vein
76. Root canal with irrigation

Working with Dual Coded Procedures

77. Partial esophagectomy with thoracic esophagostomy
78. Laryngoscopy with biopsy
79. Reattachment of left thumb and right index finger
80. Fistulectomy of the small and large intestine

PRACTICAL EXERCISE SHEET PE3-HPABG002

Title	Complete a DA Form 3647
Lesson Number/Title	HPABG002 version 1 / Diagnostic/Procedural Coding
Introduction	
Motivator	As stated in the lesson, the DA Form 3647, Inpatient Treatment Record Coversheet, serves a variety of uses. As a source document for Inpatient billing and statistical information, accuracy in preparation of this form is essential.
Terminal Learning Objective	**NOTE:** Inform the students of the following Terminal Learning Objective requirements. At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements	IAW local SOP
Risk Assessment Level	Low
Environmental Considerations	N/A
Evaluation	
Instructional Lead-In	This exercise will evaluate your ability to accurately prepare the DA Form 3647.

Resource Requirements

Instructor Materials:
DA Form 3647, Inpatient Treatment Record Coversheet - partially completed IAW the three scenarios.

Student Materials:
M-HPABG002, Student Handout
ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification
CPT4, Common Procedural Terminology, 4th Revision
PE3-HPABG002, Complete a DA Form 3647

Special Instructions

Procedures

Using the DA Forms 3647 provided by your instructor, complete the form (items 25, 26, 31 thru 36f as applicable) for each of the scenarios below.

Scenario 1: ODOM, ARCHIE C. The patient was returned to duty 31 Jan 9x. During this hospitalization, he was treated for VIRAL BRONCHOPNEUMONIA (480.9); AND ASTHMA (493.90) (PR: WRAMC, Wash, D.C., 1 May 1966. Patient received 2-units of blood and was treated with a Fiberoptic Bronchoscopy (332.2) on 29 Jan 9x.

Scenario 2: BEBAK, FRANCIS J. The patient was treated for Charcot's Arthritis, (094.0, 713.5); a condition that existed prior to entering the military (EPTS). This condition had been previously recorded at WRAMC, Washington, D. C., 19 Dec 8x. During hospitalization, the case was referred to a MEB. On 23 Jan 9x the MEB met and referred his case to a PEB. The PEB met on 28 Jan 9x and recommended TDRL (temporary disability retirement list) for PVT Bebak. He went on convalescent leave from 24 to 27 Jan 9x. Effective 3 Feb 9x, Bebak was dispositioned to TDRL under provisions of AR 635-40.

Scenario 3: KAZAKOS, NICKOLAS P. While visiting his family in San Marcos, TX, the patient became ill and was admitted to HAYS COUNTY MEMORIAL HOSPITAL, SAN MARCOS, TX. He was ABSENT SICK in that facility 2 Jan 9x to 5 Jan 9x. On 5 Jan 9x he was transported to USAH Ft. Splendid, TX. After his arrival at USAH Ft. Splendid, he was diagnosed with an ULCER OF DUODENUM, WITH HEMORRHAGE (532.40); and ACUTE NORMOCYTIC ANEMIA, DUE TO BLOOD LOSS (285.1). Patient underwent a Gastric Freezing procedure (963.2)

	on 6 Jan and 8 Jan 9x. He received 4 units of whole blood, and on 6 Jan 9x he was placed on the SI roster. He remained on the SI roster until 10 Jan 9x and was removed from the SI roster on 11 Jan 9x. Kazoka was then permitted to go on convalescent leave from 12 Feb 9x to 22 Feb 9x. On his return from convalescent leave however, he suffered a relapse and was transferred to BAMC, Ft. Sam Houston, TX on 23 Feb 9x.
Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

Using the DA Forms 3647 provided by your instructor, complete the form (items 25, 26, 31 thru 36f as applicable) for each of the scenarios below.

Scenario 1: ODOM, ARCHIE C. The patient was returned to duty 31 Jan 9x. During this hospitalization, he was treated for VIRAL BRONCHOPNEUMONIA (480.9); AND ASTHMA (493.90) (PR: WRAMC, Wash, D.C., 1 May 1966. Patient received 2-units of blood and was treated with a Fiberoptic Bronchoscopy (332.2) on 29 Jan 9x.

Scenario 2: BEBAK, FRANCIS J. The patient was treated for Charcot's Arthritis, (094.0, 713.5); a condition that existed prior to entering the military (EPTS). This condition had been previously recorded at WRAMC, Washington, D. C., 19 Dec 8x. During hospitalization, the case was referred to a MEB. On 23 Jan 9x the MEB met and referred his case to a PEB. The PEB met on 28 Jan 9x and recommended TDRL (temporary disability retirement list) for PVT Bebak. He went on convalescent leave from 24 to 27 Jan 9x. Effective 3 Feb 9x, Bebak was dispositioned to TDRL under provisions of AR 635-40.

Scenario 3: KAZAKOS, NICKOLAS P. While visiting his family in San Marcos, TX, the patient became ill and was admitted to HAYS COUNTY MEMORIAL HOSPITAL, SAN MARCOS, TX. He was ABSENT SICK in that facility 2 Jan 9x to 5 Jan 9x. On 5 Jan 9x he was transported to USAH Ft. Splendid, TX. After his arrival at USAH Ft. Splendid, he was diagnosed with an ULCER OF DUODENUM, WITH HEMORRHAGE (532.40); and ACUTE NORMOCYTIC ANEMIA, DUE TO BLOOD LOSS (285.1). Patient underwent a Gastric Freezing procedure (963.2) on 6 Jan and 8 Jan 9x. He received 4 units of whole blood, and on 6 Jan 9x he was placed on the SI roster. He remained on the SI roster until 10 Jan 9x and was removed from the SI roster on 11 Jan 9x. Kazoka was then permitted to go on convalescent leave from 12 Feb 9x to 22 Feb 9x. On his return from convalescent leave however, he suffered a relapse and was transferred to BAMC, Ft. Sam Houston, TX on 23 Feb 9x.